Arch Womens Ment Health (2004) 00: 1–12
DOI 10.1007/s00737-003-0037-1

Archives of Women's Mental Health
Printed in Austria

Original contribution

Grief and its impact on prenatal attachment in the subsequent pregnancy

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Received May 25, 2003; accepted November 10, 2003
Published online ● ●, 2004

Summary

This article suggests there is a need to reframe the phenomenon of unresolved grief in parents who are in a subsequent pregnancy after a previous loss using a prenatal attachment model. An argument is made for helping parents give meaning to their parenting role for the baby who has died so they can move forward in attaching to the baby in the next pregnancy. It is suggested that a new layer of grief surfaces when parents get pregnant again which can lead to pathology if not recognized by others. Interventions to support the parenting relationship to the baby in the subsequent pregnancy are provided.

Keywords: Grief; pregnancy; perinatal loss; prenatal attachment; parents.

Background

This paper stems from 15 years of clinical practice observing the lived experience of parents in a subsequent pregnancy that followed a perinatal loss. The interval between the time of loss and the subsequent pregnancy ranged from 6 weeks post loss to 18 years. The gestational ages of the babies that died ranged from miscarriage in the first trimester to loss in the first months of life. Yet these factors did not seem to matter in terms of the grief and attachment issues the parents discussed in a weekly educational support group.

Introduction

The literature regarding perinatal loss and its impact on a subsequent pregnancy has gained more attention in recent years, specifically how loss may affect parenting of the subsequent child. As women and their partners embark on a subsequent pregnancy heightened anxiety and fear of another loss appears to cause difficulty for mothers and fathers in forming an attachment to the new baby (Armstrong and Hutti, 1998; Davis et al., 1989; O'Leary, 2002; Peterson, 1994; Wallerstedt et al., 2003). Children born after a loss have been viewed in different ways. Some have identified a replacement child syndrome while others speak of the vulnerable child syndrome, meaning parents perceive the new infant needing special care in order to protect them from harm (Cain and Cain, 1964; Pozanski, 1972). Cote-Arsenault (2003) found mothers more diligent and overprotective with subsequent children. Green and Solnit (1964) found parents expressing the feelings that these children did not belong to them completely, but were just on loan. Others found mothers feeling a coolness toward the unborn child (Carey-Smith, 1984) or that the coming baby, at some level, *is* the baby who died (Cote-Arsenault,1995; O'Leary et al., 1998). Adult subsequent children have expressed knowledge of being born into a grieving family even when the older sibling who died was not talked about (Knight, 1997).

Conversely, on a more positive note, Carrera, Diez-Domingo, Montanana et al. (1998) found that by providing intervention in the postpartum period, women with a prior loss had similar scores on the BDI (Beck Depression Inventory) as women with no prior loss. Others have observed having a subsequent child was associated with diminished parental grief, feeling more at peace,

accepting of the loss and less guilt and depression (Theut et al., 1992; Wilson et al., 1988).

''Unresolved grief'' has been interpreted in the literature to describe parents who continue to grieve the loss of the previous baby rather than happily anticipating a baby in a new current pregnancy. Current studies suggest attachment disorders found between the mother and subsequent child one year postpartum may be due to unresolved grief (Fonagy, 2000; Heller and Zeanah, 1999; Hughes et al., 2002). Since is estimated that 59–86% of women with a periantal loss go on to become pregnant again (Cordel and Pettyman, 1994; Cuisinier et al., 1996), the conflicting data regarding parental unresolved grief and attachment disorders in subsequent children indicate the importance of this topic.

The purpose of this article is to examine grief following perinatal loss and the impact this has on the subsequent pregnancy and child. Readers will be asked to examine perinatal loss and the subsequent pregnancy from a prenatal attachment-based model. The notion of ''unresolved grief'' will be challenged. Instead, a new developmental layer of grief surfaces that can not be anticipated until one has reached the stage where one would more fully know what has been lost (Rosenblatt, 1996). Parents struggle to be a parent to two babies as they continue to be hold parental feelings for the baby who died while they begin the attachment process to the baby in the current pregnancy.

Historical overview of grief

An examination of the historical perspective on grieving provides some insight into why the term ''unresolved grief'' is used to describe the behaviors displayed by families in a subsequent pregnancy. In the eighty years since the academic secularization of bereavement, researchers have attempted to identify, describe, predict, control and even cure the behaviors of the bereaved (Hogan et al., 1996).

Freud first introduced the idea that grieving was a normal and necessary process whose function was to help the bereaved to withdraw the libido invested in the lost object so that it could be reinvested in a new object (Rando, 1983). This effort was called grief work (Stroebe and Schut, 1999). Freud saw bereavement from a psychoanalytical perspective, believing that people had to disengage from the relationship with the deceased in order to place libidinal energy into a new relationship (Freud, 1957). When the bereaved was not able to withdraw the emotional ties and instead established identification with the abandoned object, melancholia occurred.

Freud set the parameters for the ongoing study of bereavement: grief work was defined as a task; separation and relinquishment were defined as goals; and pathology was defined as holding on to the deceased. It is important to remember that although bereavement research and practice stems from the original work of Freud, Archer (1999) notes Freud never studied mourning empirically. Freud's own daughter died at the age of 29, after he had completed his work and writing on grief and its resolution. In spite of his view on how loss should be resolved, in his own life experience, writing to Ludwig Binswanger, who had just lost a son, Freud acknowledged that grief is in some sense inconsolable (Freud, 1929 as cited in Archer, 1999).

Bowlby rejected Freud's theory, instead applying attachment theory to the study of bereavement claiming a similarity in the reactions of infants separated from their mothers and bereaved adults (Rando, 1993). Although Bowlby's (1980) work was on separation of a child from his mother, not loss of an infant by the parent, in his work with widows and widowers he notes: ''It is precisely because they are willing for their feelings of attachment to the dead spouse to persist that their sense of identity is preserved and they become able to reorganize their lives along lines they find meaningful.'' (p. 98, as cited in Shaver and Tancredy, 2001). Parkes (1972) too, felt grief was a consequence of the way we form personal relationships, that the loved one is a part of the person's sense of self and the feelings of love do not go away when death occurs.

Lindemann (1944) approached grief from a medical-psychiatric point of view and predefined grief as an illness. In his study of patients undergoing psychiatric treatment he saw problems arising when people held back from ''grief work.'' Grief then became pathology in need of a cure, a theory given further supported by Engel (1961) who found an increase in mortality for the bereaved. Others theorists, using questionnaires to measure grief (Maddison and Walker, 1967; Clayton et al., 1972; Zisook et al., 1982), identified stages of grief which people must pass through leading to resolution of grief with Kübler-Ross's (1969) is the most commonly known today by the secular community.

There are two views concerning grief. The first, which has not been supported empirically, is that bereaved persons *must* grieve in a particular way, or face dire psychological consequences (Wortman and Silver, 1989). The second is the belief that systematic grief

work restores the mourner to a normal, pre-bereavement state (Strobe et al., 1996). This view suggests the expression of grief is unseemly and mourning should be completed rapidly (in several days or weeks) (Davidson, 1979). Clinical work in weekly group intervention with bereaved families in subsequent pregnancies suggest neither of these views supports the lived experience described by both mothers and fathers. Although many books are available for parents to assist with grief, the historical belief that people should ''get over it'' still abounds today and is especially true in the loss of a baby.

Loss and its impact on the experience of parenting

Infant loss shatters the survivor's most basic assumption about the world, causing parents to see the world as dangerous, unjust, and uncontrollable (Weiss, 2001). It leaves parents with an identity that has ''internalized the patterns of parenthood but with the object of their relationship no longer there'' (Riches and Dawson, 1998, p. 128). Because many early losses (i.e., miscarriage before 16 weeks gestation) are not acknowledged by society, some parents are surprised when they have feelings of grief or depression many weeks after the loss has occurred. Parents who lose an only child typically show greater distress than those who have surviving children (Archer, 1999). Still others more easily deny their role as parent (Klier et al., 2002). ''In cases where the only child died, the loss of any continuing opportunity to experience the ''lived relationship'' means that parental status is problematic, publicly difficult to define, and hard to maintain' (Riches and Dawson, 1998, p. 128). Bereaving parents have to relearn about and reinvest in a world without the deceased, and are expected by many to continue to maintain their function in an environment that does not include their child (Cordell and Thomas, 1997).

Although the normal tasks of pregnancy are not completed when a baby dies, the pregnancy did create a baby and left behind a mother and father (Leon, 1990). But the readiness to parent does not stop when a child dies (Nichols, 1989).

> *The course of the parent's development is derailed, usually abruptly, without warning, sometimes permanently. There is profound deprivation of one's instinctual urges to both give and receive, to nurture and grow, to feed and be fed. A specific person who can never be replaced has died. A part of oneself, an embodiment of the future, and the best one has to offer has died as well (Leon, 1990, p. 26).*

Infant loss leaves parents feeling that life is fragile and precious (Calhoun and Tedeschi, 2001), and vulnerable to another loss as reality cannot be trusted to be logical, predictable and understandable (Janoff-Bulman, 1992). Rather than a time of joy and expectation, a new pregnancy becomes a psychologically traumatic event. It leaves the parent feeling insecure, unworthy and unprotected, resulting in a crisis in ones life (Davis et al., 2000; Janoff-Bulman, 1992; Klier et al., 2002; Leon, 1992b). Parents can also feel less certain of their ability to protect their children as many times parents blame themselves (Janoff-Bulman, 1992). These feelings have been seen to follow into the subsequent pregnancy with an abundance of evidence suggesting that fear, anxiety, anger and the need to control specific to pregnancy concerns is higher in women and men in pregnancies after perinatal loss than those without loss (Armstrong and Hutti, 1998; Cote-Arsenault, 1995; Cote-Arsenault and Mahlangu, 1998; Cote-Arsenault et al., 2001; Franche and Mikail, 1999; Hunfeld et al., 1996; O'Leary and Thorwick, 1997; O'Leary et al., 1998; Statham and Green, 1994; Theut et al., 1992; Warland, 2000).

Prenatal attachment; challenging the medical model

Key factors in explaining a woman's reaction to the loss of her pregnancy have been suggested to be:

(a) The extent of the attachment to the baby
(b) the degree of investment in the pregnancy and
(c) although they may be influenced by, they are not necessarily determined by gestational stage (Moulder, 1994).

As one father said ''It is impossible to understand how much a parent loves a child until that child is gone'' (Levang, 1998. p. 8). It is equally impossible to understand one's attachment to an unborn child until the child is no longer physically present in your life. While the usual definition of attachment relates to the interactive process of the infant to the parent in the postpartum period, measurable at twelve months postpartum, for the purpose of this paper, prenatal attachment is defined as the relationship of the parent to the baby during pregnancy (Condon, 1993).

> *Maternal-fetal attachment is of potential significance from both theoretical and clinical perspectives. It represents the development of the earliest, most basic*

form of human intimacy . . . . Study of factors which facilitate or inhibit its development (and influence its intensity) may provide important insights into the determinants of more complex subsequent relationships such as the maternal-infant one (Condon and Cortindale, 1997, p. 360).

Attachment is different from investment in the pregnancy. Moulder (1994) suggests that "Attachment is concerned with the development of feelings for the baby, whereas investment is a more active process of involvement in the pregnancy" (p. 66). In viewing the relationship of attachment theory to perinatal loss, Robinson et al. (1999) discuss the logical extension of the work of Bowlby (1980), Klaus and Kennell's (1976) on attachment, suggesting that an individual's future behavior and the capacity to form emotional bonds may begin *in utero.* Robinson and colleagues propose using the research on parent/child attachment as a foundation for understanding the relation between attachment and perinatal loss, cautioning clinicians "that when attachment definitions include an element of time there is the potential risk for minimization of a perinatal loss" (p. 261). Infant loss represents the breaking of a *preexisting* attachment bond (Condon, 1987) to someone who would eventually have contributed to the bereaved individual's life (Archer, 1999).

Kennell et al. (1970) first interpreted the mourning process reaction they observed in women bereaved by stillbirth as further powerful evidence of antenatal emotional attachment. Profound grief reactions in fathers' bereaved by stillbirths have also been observed, suggesting a significant antenatal attachment for them as well (Condon, 1985; O'Leary, 2002; Worth, 1997). Weiss (2001) extends Bowlby and Parkes theory of grief, defining *grief* as the severe and prolonged distress that is a response to the loss of an emotionally important figure. He felt grief becomes a predictable consequence of the loss of a relationship of attachment. At a deeper, more essential level, grief has been described as the construction of a sense of a *new* "normal" that must be put in place in order that the bereaved may have a predictable and orderly world in which to function (Attig, 1991).

Others have also challenged the medical and gestational model to understand women's reactions to miscarriage believing this does not accurately reflect women's diverse experiences of the event (Moulder, 1994; Condon and Cortindale, 1997). Cote-Arsenault and Dombeck (2001) suggest the amount of anxiety experienced in a subsequent pregnancy may be related to the degree of personhood a mother assigns to her dead baby rather than the weeks of gestation when the loss occurred. Their study gives support to a model of conceptualizing attachment reactions to fetal loss in both early and late pregnancy.

The subsequent pregnancy and unresolved grief

As all past experience is filtered through the present moment (Dahlberg, Drew and Nystrom, 2001) the histories of the past and present pregnancies are intertwined. For parents who experience perinatal loss, the death is closely linked to their experience of pregnancy and birth, causing special issues to be connected with having more children (Klass, 2001). These families have lost their naivete, statistical probability has failed them (*they are the one in a thousand)* and they live with continuous anxiety that death could strike again (Kowalski, 1991). Rather than bringing feelings of starting over, a new pregnancy can reactivate emotions, triggering feelings of loss and attachment with the baby who died (Lewis, 1989; Franche and Bulow, 1999; Cote-Aresnault and Dombeck, 2001; O'Leary et al., 1998; O'Leary, 2002; Warland 2000; Wilson et al., 1988). A new developmental stage begins as parents start an active process of redefining their sense of reality (Gilbert, 1996).

Mourning is not something that can be finished. Rather, it is a process that is carried on continuously, at times nearly quiescently, and then, at times of change or developmental progression, it is reintensified as one again confronts the sadness of one's loss and experiences in a new way the need for a sense of continuity and connection with one's departed objects (Gaines, 1997, p. 568).

One mother spoke powerfully of this as she described her subsequent pregnancy. "I guess in a lot of ways, it's about grief management, because being pregnant again is the biggest reminder of the greatest loss a mother will ever experience" (personal communication, 2000). This statement speaks to the complexity of the subsequent pregnancy and the *continued* grief for one baby while wanting to be happy for a new baby coming.

While some studies have suggested that a subsequent pregnancy reduces perinatal grief (Lin and Lasker, 1996; Cuisinier et al., 1996; Theut et al., 1990) others suggest grief intensity remains high and can be an underlying current throughout the subsequent pregnancy (Franche and Bulow, 1999; O'Leary et al., 1998). Using attachment theory as a contextual basis for examining grief, it is not surprising to discover literature suggesting parents

hold back attachment in the subsequent pregnancy out of fear of this separation (loss) again (Armstrong and Hutti, 1998; Cote-Arsenault and Mahlangu, 1999; Davis et al., 1989; Klass, 1988; O'Leary et al., 1998; Peterson, 1994; Theut et al., 1992). The subsequent child does not resolve the loss of the sibling that has died but, in simple terms, becomes another baby, a sibling to the baby who died.

What contributed to unresolved grief and pathology?

Bowlby (1980) believed that grief responses were instinctual, adaptational, and valuable for survival and when grief responses were blocked (*as in denying or negating ones parenthood to a baby who died*), they become split off and repressed. Moreover validation of the loss has been found to be of particular importance in facilitating a healthy grieving process (Robinson, et al., 1999). One factor described by Leon (1990) that make the death of a baby particularly challenging is the lack of social support and understanding, adding insult to injury for the parents after a baby's death. Parents have reported their family and friends expect them to replace the child quickly as a means of recovery (Powell, 1995, O'Leary et al., 1998) and are surprised that parents continue to mourn the loss of the previous child when they become pregnant again. They assume the parents did not really ''know'' their baby, and compared to other instances of loss believe, ''now they will 'get over' their grief.'' Keyser (2002) speaks of how difficult it is for others ''to catch the essence of who that child is to its parents – let alone validate the many layers of grief, each with its own set of intricately woven feelings, thoughts and images'' (p. 229). Condon (2000) observed that often the mothers' own healthy intuitive responses to their grief were overridden by the maladaptive reactions of the social network.

It has been suggested that when the memory of the child that the parents work to keep alive is not shared by their support system or the inner representation becomes intertwined in individual or family pathology, problems can arise (Detmer and Lamberti, 1991; Klass, 1999) and can account for persistence in grieving. Parents may also feel a responsibility to be sad, otherwise the child will be forgotten. This can cause parents to believe that reinvesting in other relationships (*such as attaching to a subsequent child*) and attending to other matters would mean that they have forgotten and abandoned their deceased child (Cordell and Thomas, 1997; Davis et al., 2000; Klass, 1988; O'Leary et al., 1998; Weiss, 2001). Failure to offer support or to provide a context in which to receive support for still being a parent to the baby who died may lead families to believe no one cares. This can heighten parents sense of isolation and delay them in moving forward with their grief work (Nichols, 1989). While these parenting behaviors were often mistakenly viewed by others as ''unresolved grief,'' in order for parents to take on a new pregnancy and the new baby, the parenting relationship of all the children in the family needs to be acknowledged (O'Leary et al., 1998). Significant people who do not give validation to the meaningfulness of the continued parenting relationship for the baby who has died can unknowingly impede the parents' ability to understand why attaching to a new baby in the subsequent pregnancy can be so difficult.

Why is there lack of support?

There are several speculations as to why lack of support occurs. Support people may be uncomfortable with death (Sidmore, 2001), expect this type of loss to disappear, and withdraw or provide little support or recognition of the child (Cordell and Thomas, 1997; Davidson, 1979; Wortman and Silver, 1989). Potential support providers may have limited understanding of the sequel of traumatic losses or the accompanying losses that may face the survivor. They may assume that shortly following the loss, individuals resolve and recover from the death. (Davis et al., 2000; O'Leary and Thorwick, 1997). The most common way of viewing pathology has been the notion of an inhibited or derailed mourning process in the stage model of bereavement (Kübler-Ross, 1969). Hagman (2001) suggests that even pathologic grief is meaningful, however disturbed and painful it appears. Because of their assumptions regarding resolution and recovery, outsiders may regard the survivor's continuing search for meaning, lack of resolution, or displays of distress as a sign of character weakness or personal pathology, rather than as a legitimate response to the loss. And finally, supporting the bereaved takes much physical and psychological energy, and this can be difficult for people to sustain for any substantial length of time.

Hagman (2001) describes mourning as fundamentally an intersubjective process. He suggests problems arising from bereavement are due to the failure of other survivors to engage with the bereaved person in mourning together. Three factors should be considered before

assigning pathology or unresolved grief to parents in a subsequent pregnancy:

(a) Whether there has been a failure of the social surround to assist with mourning;
(b) how the parent is attempting to maintain meaningful life experience in the face of loss; and
(c) how the parent is attempting to hold onto the tie to the deceased person, thus preserving a threatened relationship (p. 23).

Grief and depression in the subsequent pregnancy

Davis et al. (2000) found parents who lose a child are not only likely to struggle with issues of finding meaning, but are more likely to experience long-term depression and anxiety. Others found women whose previous pregnancy had ended in stillbirth were significantly more depressed in the third trimester of the subsequent pregnancy and experienced higher state anxiety if conception occurred within a year after the stillbirth compared with conception occurring later (Hughes et al., 1999). They reported 21% of women with a previous stillbirth had PTSD symptoms in the third trimester of the next pregnancy.

In the postpartum period, women with a previous loss appear to be more vulnerable to feeling anxious, distressed, and depressed than women with no history of loss (Hunfeld et al., 1997). These women viewed their babies as being significantly less ideal than the controls at 16 weeks postpartum. They reported more problems around their infants crying, sleeping, eating and acquiring a regular pattern of behavior. The negative emotions and problems in mother-infant adaptation applied to those with and without a previous normal birth and contradict their previous study (Hunfeld et al., 1996). In both studies women with high trait anxiety showed more negative emotions and problems in mother-infant adaptation than the women with low trait anxiety.

These studies verify Main and Hesse's (1990, 1992) finding that the parents' unresolved grief, measured in a very specific and reliable way, predicted children's disorganized attachment. This gives support to Bourne and Lewis' (1984) theory of psychological danger when mourning is delayed by a new pregnancy. It is important to keep in perspective that research regarding the *nature* of anxiety symptoms and disorders is scant (Engelhard et al., 2001). Moreover there have been few descriptive studies done on what the cause of the symptoms of PTSD were for parents in their subsequent pregnancy.

Depression versus grief

It is important to recognize that grief and depression often exhibit the same type of symptoms and applying a global measurement of depression as an indicative of unresolved grief is not adequate (Leon, 1992b). What can be normal grieving behaviors others may view as depression, suggesting these behaviors are not necessarily pathological reactions. Klier et al., (2002) suggest that yearning and pining for the deceased, as distinct from depressive symptoms, may be a cardinal feature of reactions to loss. They wisely suggest that women who experience significant clinical depression and/or grief after loss should be followed until after the birth of the subsequent child. In addition, delayed grief reaction have been found to occur more often in men (Janssen et al., 1996). Byrne and Raphael (1997) have provided evidence that core features of grieving focusing on disruptions in the attachment relationship to the lost loved one are relatively independent and different from general depression. If mothers (*and fathers*) continue to display significantly higher grief scores at 16 months after the birth of the subsequent child (Theut et al., 1990) perhaps we need to measure grief further out than one year postpartum. What may need to be examined more closely are: (a) Can depressive symptoms that are similar to grief symptoms be differentiated in order to more appropriately treat depression, and (b) which families are more at risk for developing long term depression that may negatively affect their parenting.

In viewing loss from an attachment based model, attachment relationships are known to endure, with some losses being so big and painful that one cannot ever get to a place where grief has ended (Rosenblatt, 1996). Lin and Lasker (1996) propose that a subsequent pregnancy or birth may help lessen the grief reactions but grief is not necessarily resolved by these events. They reported that all of their groups maintained a certain mean level of grief symptoms even two years post-loss. Although depressive symptoms in a subsequent pregnancy were found to be greater in mothers and fathers with a history of perinatal loss compared to those experiencing their first pregnancies (Armstrong, 2002; Franche and Mikail, 1999), there was no indication in either study that the depression symptoms warranted psychological therapy.

Grief states, irrespective of the nature of the loss, are not ended by replacement of the lost person. Despair continues even when what might seem to others to be substitutive relationships are available (Weiss, 2001). While acknowledging pregnancy loss is a stressful life

event that can cause marked deterioration in a woman's (*and partner's*) mental health, the majority of women are able to recover without psychiatric treatment (Janssen et al., 1996).

Parenting intervention

The replacement child pathology has been challenged as largely a conceptual argument based on clinical findings and small cases from psychiatric literature (Grout and Romanoff, 1999; Powell, 1995) which does not do justice to the complexity of parental representation of the dead child and the family constellation. As parents enter a subsequent pregnancy they begin an active process of redefining their sense of reality (Gilbert, 1996). Their grief is an effort to communicate parental feelings for the baby who died that can conflict with their need to think about being a parent to a new baby who they also fear could die. This cannot be anticipated nor worked with until the parent is pregnant again. ''I thought I was ready. I thought I had resolved my loss.'' It is simply part of the developmental process.

Attachment bonds cannot be relinquished, but they can be reworked or transformed in such a way as to leave room in the psychic organization of the individual for the development of new attachments (*a new baby*) and a new locus in the social order (Romanoff and Terenzio, 1998). Grief and attachment have been observed to occur simultaneously for parents in a pregnancy after loss (Kamm and Vandenberg, 2000; O'Leary et al., 1998; O'Leary, 2002; Powell, 1995; Rando, 2000). This negates Bourne and Lewis's argument of delaying grief. What appears to be more useful is for professionals to provide support that acknowledges how the past history and baby may be impacting the new pregnancy and attachment to the new baby.

Facilitating mothers' (*and fathers*) expressions of grief for one baby and attachment to a new baby helps preserve the space in the family that the dead child would have inhabited (Grout and Romanoff, 1999; O'Leary, 2002; Powell, 1995). Dead babies can be remembered while new babies are slowly accepted, with the realization that a new baby does not require wiping out all memories and love for the other baby

Table 1. Bringing the concept of parenting into pregnancy

- Their previous pregnancy is their historical perspective. Know the dates and gestational age of the previous loss (es), how the baby died and the baby's name. This alerts you to times when parents may be more anxious in the current pregnancy, thinking about the baby who died and worrying about the new baby's safety. It is not unusual to see families thinking something is wrong during these times.
- Encourage them to ask for heartbeat checks when they need it. Besides giving needed reassurance, this helps remind them a *baby is present.* For some parents, knowing there is a plan for dealing with their fear ameliorates the anxiety.
- ''*It affects me too but nobody asks.*'' Remember the partners are grieving and need support. They can be just as anxious and fearful about the baby as the mothers but often try valiantly to cover this to protect the mother.
- Fetal movement in the current pregnancy can be a reminder of the baby who died and bringing up loyalty issues. Parents may need to work through the realization that this baby in utero is not the baby who died and be reminded they are still parents to the other baby. As the baby develops in utero, parents gradually realize that avoiding attachment will not save them from the pain of loss.
- Because parents are more attached to the baby who died, suggest they start a journal to the previous baby about the new baby. This helps them begin to see the two babies as *separate* individuals. As the pregnancy progresses the movements of the current baby will draw them forward into the present. The journal then becomes directed to their live baby *about* the baby who died.
- Remind the parents that the current baby can hear their voices. This helps parents know that the baby, at some level, is aware of their fears and anxieties and feels the grief, love and overwhelming need the parents have to protect him or her.
- Woman need to learn the differences between contractions and fetal movements. Reassure them it is okay for the baby to have quiet times as fetal movement's are cyclical, with its various states. The awareness of the woman's body's changes and of the baby's ongoing development and *presence* helps them in parenting the baby now.
- When the current baby exceeds the gestational age of the prior baby's loss parents need information on normal physiology of pregnancy. They may think something is wrong again as they have no foundation to trust their own bodies and the normal process of pregnancy.
- Legitimizing their fears lets them know that you are listening to them. By helping parents explore constructive ways to cope you enable parents to become advocates for themselves and their new baby. They begin to gain a sense of control and appreciated that they actively can parent their new baby even before birth.
- Medical procedures can stimulate memories of the previous baby and in some cases severe flashbacks can occur. Healthcare providers should ask before a procedure if this will bring up memories of the last time, and find out what they may need to help them through the ultrasound, test, or clinic visit.
- The previous pregnancy is their historical perspective; birth meant death. Parents traumatized by loss often lay some or all of the blame on others so can be extraordinarily suspicious and abrasive in manner. Their need to control is a parenting instinct that provides protection for the baby and themselves against the pain of another loss. No absolute guarantees can be given and they know it, but your shared, honest opinion can be heard.
- Helpers must grieve too. If you are not comfortable with your own grief issues this can cause difficulties. Give support to each other by processing difficult situations with colleagues. There is evidence suggesting that professionals who work under major stresses without relief are at risk of physical as well as emotional illness. NUTURE YOURSELF SO YOU CAN NUTURE THE FAMILY.

(Cote-Arsenault, in press). As gestation proceeds in the subsequent pregnancy, the behavioral abilities of the new baby become more refined, causing the baby to elicit an awareness of his or her presence to the parents (O'Leary and Thorwick, 1993). Educating parents on fetal competencies and the presence of the new baby *in utero* helps parents begin to understand the prenatal relationship they are forming in the current pregnancy (O'Leary et al., 1998; Verny, 2002). The fetal competencies of the former baby are also stressed, giving parents the knowledge that the baby who died knew them as his or her parents during that pregnancy. This integrates the parent's representation of the baby who died in a different way (Klass, 1997) rather than having them sever that relationship to embrace the new baby.

Intervention that improves the maternal-fetal relationship during the subsequent pregnancy has been supported in many studies (Condon and Corkindale, 1997; Franche and Mikail, 1999; Hunfeld et al., 1997; O'Leary, 2002) and may have long-term beneficial consequences. Keeping a connection to the baby who died within their family story has been found to be a healthy form of adaptation and helps make way for emotional energy to develop new relationships (Attig, 2001; Cote-Arsenault, 2003; Klass, 1993; O'Leary and Thorwick, 1997; O'Leary et al., 1998; Romanoff and Terenzio, 1998). Addressing the past grief has also been found to help enhance and make fuller the present and future (Curzie-Gajdos, 2001; Speckhard, 1997), especially in regard to intergenerational effects of grief and trauma. Parents often said that they didn't know what to do with the feelings of grief until they were helped to label these feelings as parenting behaviors stemming from their attachment to the previous baby.

Discussion

In the realm of infant loss and the baby in the subsequent pregnancy, any meaningful discussion must inevitably utilize the concept of antenatal emotional attachment and recognize that, psychologically, pregnancy is the gestation of a person who acquires increasing reality, humanness and emotional relevance. While not all families may need structured intervention to support prenatal attachment to the subsequent child, it is important to ask all families: ''How do you view your losses?'' This allows the mother and father/partner to give meaning to their experiences (Leon, 1992a; Speckhard, 1997; O'Leary et al., 1998) rather than assuming that they have unresolved grief. Some parents may view an early miscarriage as only the promise of a baby. Others may have already invested in, visualized, and named the baby. This approach supports the theory that attachment and investment are separate but linked processes that develop at varying rates for different women and men and in different pregnancies. Clinical practice also demonstrated the need to ask parents periodically ''how things are going'' and not assume because they did not want help initially ''all is well.'' Many parents are invested in ''looking good'' for their health care provider and may have flashbacks at the time of birth if they haven't processed the previous birth. As parents get closer to their due date they may be more open to supportive intervention in planning for their labor and birth (Parker and O'Leary, 1989).

Interconceptional counseling for families has also been recommended as an avenue for couples to discuss previous losses, gain an understanding of what may have gone wrong and what preventive measures might be taken for the next pregnancy, (Wallerstedt et al., 2003). This could also be a time to help parents understand that their grief may not recede if they become pregnant again and that this is normal. Providing opportunities for parents to talk about their reactions to loss and their feelings in the subsequent pregnancy supports them in knowing that their feelings are accepted (O'Leary et al., 1998; Wallerstedt et al., 2003; Wilson et al., 1988). Helping them to make meaning of their loss also appears to decrease depression and there is less chance of grief becoming pathological (Attig, 2001; Gaines, 1997; Shapiro, 1996). It is important to keep in perspective that previous loss does not necessarily presage disordered parenting in the years to come (Grout and Romanoff, 2000) nor long term psychological problems (Robinson et al., 1999). Indeed a new pregnancy has been found to be healing for many families (Klier et al., 2002; O'Leary et al., 1986).

Future research

There continues to be a need for more research on the impact of infant loss and how parents cope in the subsequent pregnancy and the effect on their parenting of the subsequent child. The problem arises in choosing appropriate methodology which Klier and colleagues (2002) have pointed out in their comprehensive review of the literature on miscarriage. Loss of a child changes ones' image of self as a parent so dramatically that it is difficult to make a comparison between parents who have suffered a loss with parents who have not had a loss. What therapists call ''pathological responses'' may be merely unsuccessful strategies to maintain meaning

and preserve the attachment to the lost object that others are asking them to forget. It is important to be aware that, no matter how withdrawn into grief a person appears to be, he or she is struggling to maintain relatedness, whether to the internal representation of the dead person or to the social surround (Hagman, 2001).

Neimeyer (2000) argues that the medically oriented researchers, at a methodological level, may be assessing an inappropriate domain of outcome, focusing on psychiatric and physical problems, rather than features distinctive to grief *per se*. He recommends moving away from the medical model and focusing intervention on the meaning reconstruction in response to a loss as a central process in grieving. This belief has been substantiate by others as well (Condon and Cortindale, 1997; Moulder, 1994; O'Leary, 2002). Although only one empirical study has examined the model of prenatal parenting in a support group setting, parents reported being empowered to advocate for themselves and their babies while feeling better equipped to deal with the uncertainties of their pregnancies (Cote-Arsenault, in press).

Resolution of grief speaks to the past, letting go or leaving behind. We don't lose or leave behind our traumas but we can learn ways to transcend them as they make us who we are today. What may be more important to examine is what is different about parents who do not have attachment disorders in respect to their subsequent children and those families who do have disorders. What were the histories of the parents that managed better? What were the variables around their loss? Did they have sensitive care providers who were comfortable with their own grief issues and were more able to support these parents at the time of death? Did they have educational intervention that spoke to the prenatal attachment relationship for the baby who died to help them in attaching to the baby in the subsequent pregnancy? Are we asking mothers *and* fathers how the lived experience of parenting is different when loss occurs? This will influence how they accept a new pregnancy and baby.

It has been suggested that inconsistencies in the literature may be due to methodological designs of studies (Klier et al., 2002) and differentiating between women for whom pregnancy aids in resolving grief and women for whom pregnancy represents a way of avoiding grief (Zeanah, 1989). While it is important to remember that people with different attachment histories handle emotions and grief differently (Shaver et al., 2001), others propose that attachment research remains central to understanding grief (Stroebe et al., 2001). This seems to be is especially true in the area of perinatal loss and gives support for the need to do a comprehensive study of prenatal attachment with both mothers and fathers, both in normal pregnancies and those in a pregnancy that follows a perinatal loss. In addition, a phenomenological methodology may further guide intervention by providing an understanding to the meaning of the symptoms of post-traumatic-stress identified in these families.

Conclusion

When parents enter a subsequent pregnancy the meaning of their *parenting* relationship and attachment to the baby who died is often denied. This may be a factor that can interfere with parents risking attacment to another baby, causing what appears to be unresolved grief. The phenomenon of unresolved grief should be viewed with reservation and caution. Not all mothers or fathers in a subsequent pregnancy have anxiety or severe depression that would lead to attachment disorders or pathology. With the growing recognition that mourning is intersubjective, meaningful and concerned with continuity of the tie with the deceased person, assessment of pathology needs to be re-evaluated. What is normal and what is pathological must be considered in the context of the parent's specific personality, relationship to the deceased person, and his or her familial and cultural background.

Finding new meaning in life and regaining trust in the world appears to be a process that develops over time as parents watch their subsequent child grow. The following quotes (excerpts from video, O'Leary and Thorwick, 1995) illustrate how long it can take for parents to trust in the world again. This mother is not reflecting unresolved grief but her courage to reinvest in the future and journey to finding meaning in her parenting role again.

> *"For about the first three years of her life I was checking her nightly to make sure she was alright. I just did not trust that all was well. That has come . . . . I've empowered myself to move forward and be the mother that I want to be, without shackles, without dragging a lot of baggage. And learning how to be a good parent, minus the grief, the intense grief. Being present for my children and playing with them and feeling that joy of being a mom."*

While acknowledging the joy of having a healthy subsequent daughter this father shares his continued relationship with his deceased son two years after his death.

> *"Everything works out and now we have a beautiful daughter. We count our blessings everyday with her and still grieve Calvin, just less intensely and less*

frequently. But I don't think a day goes by without thinking about him.''

As professionals we must respect parents' journey in finding a place in their lives for the baby who died and help them move forward as changed mothers and fathers. Although the concept of prenatal attachment continues to hold controversy in the scientific community, many bereaved parents acknowledge that they had an attachment to their unborn child who died. Viewing infant loss from a parenting perspective is different from expecting parents to ''move on'' or labeling their grief as being unresolved. You never stop being a parent to your children, even when they die. If parental feelings of grief for a deceased baby, occurring along side their struggle to attach to a new baby, are not acknowledged as normal, the parents and subsequent children are indeed at risk for mental health disorders.

Acknowledgement

I would like to acknowledge editing assistance from Clare Thorwick, RN and Lynnda Parker, BSN. I would also like to acknowledge the many families who taught me to look beyond their grief to their experience of being a parent. Financial support for this paper was provided, in part, by the Bush Foundation of St. Paul, MN.

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